PRINTED: 07/17/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G215	A. BUILDING _____ B. WING _____	07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC X	1449 ROXANNA RD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A initial certification survey was conducted on July 12, 2007 utilizing the full survey process. One male client is currently residing in the facility and the facility has a capacity for four clients. This client was diagnosed as having mild mental retardation. The findings of this survey were based on observation, interviews with the facility management and direct care staff and the review of administrative and habilitation records to include the review of unusual incident reporting system. This Wholistic Habilitation Services facility is in compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vice President TITLE: Mattie Shaw (X6) DATE: 7/24/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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I 000	INITIAL COMMENTS A licensure survey was conducted on July 12, 2007. One male client is currently residing in the facility and the facility has a capacity for four client. This one client is diagnosed as having mild mental retardation. The findings of this survey were based on observation, interviews with the facility management and direct care staff and the review of administrative and habilitation records to include the review of unusual incident reporting system.	I 000		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents being stored. The findings include: During the environmental walk-through on July 12, 2007 at approximately 1:30 PM revealed the following; Caustic agents were being stored in the basement in the laundry area in storage several cabinets which were unlocked. Additionally, a variety of caustic agents were also observed on a shelf above the washer unlocked and unsecured.	I 095	All caustic and poison agent have been locked.	7/16/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and	I 206		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Vice President (X6) DATE 7/24/07

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I 208	Continued From page 1 annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The findings include: On July 12, 2007, review of health certificates revealed failure by the GHMRP to show evidence of current health certification for the following: - two direct care staff [Staff #1and Staff #2]; - one registered nurse	I 208	Staff # 1 is no longer in the home. He failed to show up for additional Training. Please find Staff # 2 and RN physicals.	7/16/07
I 221	3510.2 STAFF TRAINING Orientation training shall be the responsibility of each GHMRP and shall be documented in each employee ' s personnel folder. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all staff received their initial orientation training. The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 11:30 AM revealed that	I 221		

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I 221	Continued From page 2 the direct care staff #1 was recently employed by the agency. Review of the available training manual failed to reflect that staff #1 had participated in orientation training prior to or after employment as required by the agency's policies.	I 221	Staff #1 has been terminated for failure to attend training pursuant to this POC. All Staff in home have been trained	7/22/07
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to recognize signs and symptoms of illness and implement of emergency measures for the residents in the facility. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 1:00 AM revealed that all staff on the staffing schedule was not trained in CPR. Record review on July 12, 2007 revealed that Staff #1 and Staff #3 did not have current CPR certifications. 2. Interview with the QMRP on July 12, 2007 at approximately 1:00 AM revealed that all staff on the staffing schedule was not trained in First Aid. Record review on July 12, 2007 revealed that Staff #1 and Staff #3 did not have current First Aid certifications.	I 227	Staff 1 is nolonger in the home. Staff # 3 has current CPR + First Aid. Please find attached.	7/16/07

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R 000	INITIAL COMMENTS A licensure survey was conducted on July 12, 2007. One male client is currently residing in the facility and the facility has a capacity for four client. This one client is diagnosed with mild mental retardation. The findings of this survey were based on observation, interviews with the facility management and direct care staff and the review of administrative and habilitation records to include the review of unusual incident reporting system.	R 000		
R 125	4701.6 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions who have worked or resided within the seven (7) years. The finding includes: Review of the personnel files on July 12, 2007 at approximately 12:30 PM revealed the GHMRP failed to evidence criminal background checks for one direct care staff #1.	R 125	Staff #1 is no longer in home for failure to attend training pursuant to this POC. All staff have criminal background checks.	7/16/07

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Martha Thomas
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Vice President

(X6) DATE: 7/24/07

STATE FORM DBKY11 If continuation sheet 1 of 1